STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 00 B. WING	10/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

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F000000		F000000		

This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 8/22/14.

Survey dates: October 7 & 8, 2014.

Facility number: 000369
Provider number: 155530
Aim number: 100275190

Survey team:
Heather Tuttle, RN, TC
Lara Richards, RN
Cynthia Stramel, RN
Yolanda Love, RN

Census bed type:
SNF/NF: 68
Total: 68

Census payor type:
Medicare: 6
Medicaid: 59
Other: 3
Total: 68

These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.

Quality review completed on October 15,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	2014, by Janelyn Kulik, RN.			
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			

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	Based on record review and interview, the facility failed to ensure the residents' Physician was notified of abnormal laboratory results in a timely manner as well as notification related to Coumadin (a blood thinner) orders for 2 of 3 residents reviewed for notification of change. (Residents #2 and #105) Findings include: 1. The record for Resident #105 was reviewed on 10/8/14 at 9:00 a.m. The resident's diagnoses included, but were not limited to, hypertension and stroke. A Physician's Order dated 9/25/14, indicated the resident was to have a PT/INR blood test (a blood clotting study) weekly. A Physician's Order dated 9/30/14, indicated to hold the Coumadin for three days (Tuesday, Wednesday and Thursday). Repeat PT/INR on Friday 10/3/14 then continue PT/INR weekly on Wednesday. This order was obtained from the resident's previous primary Physician, not her current Physician. There were no lab results in the resident's record at this time. There was also no documentation in the Nursing Progress Notes on 10/3 or 10/4/14 indicating the	F000157	The facility will insure that residents' physicians are notified of abnormal laboratory results in a timely manner The two residents identified during the survey have had their results report to the physician No new orders noted for resident #105. For resident #102, per physician, the resident was transferred to the hospital for evaluation/transfusion. No additional outcome for the resident. DON or designee have completed a 100% audit in the facility to insure that all abnormal lab results have been reported to the physicians per facility policy. No additional issues identified. Per issues identified, audits have been increased from weekly to 3 times per week. Nursing staff will be in-serviced on notification and the necessity to report abnormal lab results to physicians in a timely manner. Results of lab audits will be reported to the QA Team at least monthly on an on-going basis Request Paper Compliance for resolution of this citation	10/31/2014

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	Physician was notified of the lab results and no orders to continue to hold the Coumadin or resume the Coumadin. LPN #1 contacted the laboratory and the PT/INR results from 10/3/14 were faxed to the facility. Review of the 10/2014 Medication Administration Record (MAR), indicated the Coumadin was held 10/1 and 10/2/14. There were no doses of Coumadin given between 10/3 and 10/8/14. Interview with the Director of Nursing on 10/8/14 at 11:00 a.m., indicated the resident's Physician should have been notified of the PT/INR results from 10/3/14 and orders should have been clarified related to the administration of the Coumadin. 2. The record for Resident #2 was reviewed on 10/08/14 at 9:09 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, chronic kidney disease, and anemia. Review of Physician Orders dated 6/26/14, indicated a Complete Blood Count (CBC) every three months. Review of the 9/2014 recap indicated Complete Metabolic Panel (CMP) and CBC every 3 months. Last one completed 6/27/14.			

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	Review of the laboratory data collected on 9/26/14 indicated a CBC was completed. The resident's Red Blood Cell (RBC) was 2.94 (a low count: normal was 3.63-5.04), Hemoglobin (HGB) was 7.8, (a low reading: normal was 12-15.3), and the Hematocrit (HCT) was 23.9 (a low reading: normal was 34.7-45.1). Further review of the lab sheet indicated the lab was printed at the facility on 9/27/14 at 3:06 p.m. Continued review at the bottom of the page of the 9/26/14 CBC indicated "Faxed (Physician Name) 9/29." Review of Nursing Progress Notes dated 9/27, 9/28, and 9/29/14 indicated there was no evidence of any documentation the Physician was notified of the abnormal labs. Continued review of Nursing Progress Notes dated 9/30/14 at 11:30 a.m., indicated "Resident's family and Physician notified at this time regarding abnormal labs...." Review of Nursing Progress Notes dated 10/1/14 at 11:20 a.m., indicated "Spoke with MD (Medical Doctor) in regards to abnormal labs. MD sent orders to transfer resident to hospital to have two units of transfused packed red blood cells...." Further review of Nursing Progress Notes dated 10/2/14			

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	at 6:00 a.m., indicated the resident was transferred to the hospital for the transfusion. Continued review of 10/2/14 Nurses Notes indicated the resident was admitted to the hospital with the diagnosis of anemia. Review of the current and undated Notification for change in resident condition or status policy provided by the Director of Nursing (DON) indicated "The nurse supervisor/charge nurse will notify the resident's attending Physician or on-call Physician when there has been a need to alter the resident's medical treatment significantly." Interview with the DON on 10/08/14 10:32 a.m., indicated there was no documentation of Physician notification on 9/27/14 when the lab was printed at the facility. She indicated the first time the Physician was notified was on 9/29/14 by the way of a fax and she informed the staff nurse they needed to call the Physician instead of faxing, due to the labs being so low. She indicated the Physician was notified per telephone on the 10/1/14 This deficiency was cited on 8/22/14. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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F009999	3.1-5(a)(2)	F009999	xxxxxxxx	10/31/2014